

109TH CONGRESS
1ST SESSION

H. R. 747

To amend title XI of the Social Security Act to achieve a national health information infrastructure, and to amend the Internal Revenue Code of 1986 to establish a refundable credit for expenditures of health care providers implementing such infrastructure.

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 10, 2005

Mr. GONZALEZ (for himself, Mr. McHUGH, Ms. JACKSON-LEE of Texas, Mr. TOWNS, Mr. LIPINSKI, Mr. HINOJOSA, Mr. CROWLEY, Mrs. CHRISTENSEN, Mr. MOORE of Kansas, and Mr. MILLER of North Carolina) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XI of the Social Security Act to achieve a national health information infrastructure, and to amend the Internal Revenue Code of 1986 to establish a refundable credit for expenditures of health care providers implementing such infrastructure.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as “National Health Informa-
3 tion Incentive Act of 2005”.

4 **SEC. 2. FINDINGS AND PURPOSE.**

5 (a) FINDINGS.—The Congress finds as follows:

6 (1) A March 2001 Institute of Medicine
7 (“IOM”) study concludes that in order to improve
8 quality, the nation must have a national commit-
9 ment to building an information infrastructure to
10 support healthcare delivery, consumer health, quality
11 measurement and improvement, public account-
12 ability, clinical and health services research, and
13 clinical education.

14 (2) A November 2001 National Committee on
15 Vital Health Statistics study lauds the importance of
16 a national health information infrastructure to im-
17 prove patient safety, improve healthcare quality, im-
18 prove bioterrorism detection, better inform and em-
19 power healthcare consumers regarding their own
20 personal health information, and to better under-
21 stand healthcare costs.

22 (3) An October 2002 IOM report calls on the
23 federal government to take steps to encourage and
24 facilitate development in the information technology
25 infrastructure that is critical to healthcare quality
26 and safety enhancement.

1 (4) A General Accounting Office October 2003
2 report found that the benefits of an electronic
3 healthcare information system included improved
4 quality of care, reduced costs associated with medi-
5 cation errors, more accurate and complete medical
6 documentation, more accurate capture of codes and
7 charges, and improved communication among pro-
8 viders enabling them to respond more quickly to pa-
9 tients' needs.

10 (5) Other studies and surveys show that culti-
11 vating a national healthcare information infrastruc-
12 ture and improving patient care will depend crucially
13 on adoption of uniform medical data standards and
14 interoperability.

15 (6) Acquisition costs, physician and staff time
16 required to transition from paper-based offices to
17 electronic health systems, and the lack of industry
18 standards on interoperability are the principle bar-
19 riers to creating a national health information infra-
20 structure.

21 (7) The success of a national health informa-
22 tion infrastructure depends on the widespread use
23 and acceptance of electronic health records in physi-
24 cian offices.

1 (b) PURPOSES.—The purposes of this Act are as fol-
2 lows:

3 (1) To facilitate the development of standards
4 and to create incentives that encourage physicians
5 and other health professionals to adopt interoperable
6 electronic health records, electronic prescribing sys-
7 tems, evidence-based clinical support tools, patient
8 registries, and other health information technology
9 as a key component of a national health care infor-
10 mation infrastructure in the United States to ensure
11 the rapid flow of secure, private and digitized infor-
12 mation relevant to all facets of patient care.

13 (2) To do so in a voluntary manner that does
14 not become an unfunded mandate on small physician
15 practices.

16 (3) To do so in a manner that does not com-
17 promise the health care provider's ability to make
18 patient care decisions based solely on his or her clin-
19 ical expertise and experience, and what the provider
20 concludes is the best for a particular patient based
21 upon scientific evidence and knowledge of the pa-
22 tient's medical history.

1 **SEC. 3. OFFICE OF THE NATIONAL COORDINATOR FOR**
2 **HEALTH INFORMATION TECHNOLOGY.**

3 (a) ESTABLISHMENT.—There is established within
4 the executive office of the President an Office of the Na-
5 tional Coordinator for Health Information Technology (re-
6 ferred to in this section as the “Office”). The Office shall
7 be headed by a Director appointed by the President. The
8 Director of the Office shall report directly to the Presi-
9 dent.

10 (b) RESOURCES.—The President shall make available
11 to the Office the resources, both financial and otherwise,
12 necessary to enable the Director of the Office to carry out
13 the purposes of, and perform the duties and responsibil-
14 ities of, the Office.

15 **SEC. 4. STANDARDS FOR BUILDING THE NATIONAL HEALTH**
16 **INFORMATION INFRASTRUCTURE.**

17 Title XI of the Social Security Act (42 U.S.C. 1301
18 et seq.) is amended by adding at the end the following
19 part:

20 **“PART D—STANDARDS FOR BUILDING THE NA-**
21 **TIONAL HEALTH INFORMATION INFRA-**
22 **STRUCTURE**

23 **“SEC. 1181. STANDARDS FOR BUILDING THE NATIONAL**
24 **HEALTH INFORMATION INFRASTRUCTURE.**

25 “(a) STANDARDS.—

26 “(1) DEVELOPMENT AND ADOPTION.—

1 “(A) IN GENERAL.—The Secretary,
2 through the Office of the National Coordinator
3 for Health Information Technology and in col-
4 laboration with the Committee on Systematic
5 Interoperability, shall develop or adopt stand-
6 ards for transactions and data elements for
7 such transactions (in this section referred to as
8 ‘standards’) to enable the creation of a national
9 health care information infrastructure.

10 “(B) ROLE OF STANDARD SETTING ORGA-
11 NIZATIONS.—

12 “(i) IN GENERAL.—Except as pro-
13 vided in clause (ii), any standard adopted
14 under this section shall be a standard that
15 has been developed, adopted, or modified
16 by a standard setting organization.

17 “(ii) STANDARD SETTING ORGANIZA-
18 TION.—For purposes of this section, the
19 term ‘standard setting organization’ means
20 an organization accredited by the Amer-
21 ican National Standards Institute that de-
22 velops standards for information trans-
23 actions, data elements, or any other stand-
24 ard that is necessary to, or will facilitate,
25 the implementation of this part.

1 “(C) CONSULTATION.—In developing and
2 adopting standards, the Secretary shall consult
3 with national organizations representing physi-
4 cians in clinical practice, hospitals, pharmacists,
5 pharmacies, pharmaceutical manufacturers, pa-
6 tients, standard setting organizations, phar-
7 macy benefit managers, beneficiary information
8 exchange networks, technology experts, and rep-
9 resentatives of the Departments of Veterans Af-
10 fairs and Defense and other interested parties.

11 “(D) ASSISTANCE TO THE SECRETARY.—
12 In complying with the requirements under this
13 section, the Secretary shall rely on the rec-
14 ommendations of the National Committee on
15 Vital and Health Statistics established under
16 section 306(k) of the Public Health Service Act
17 (42 U.S.C. 242k(k)), and shall consult with ap-
18 propriate Federal and State agencies and na-
19 tional organizations. The Secretary shall pub-
20 lish in the Federal Register any recommenda-
21 tions of the National Committee on Vital and
22 Health Statistics regarding the adoption of a
23 standard under this section.

1 “(2) OBJECTIVE.—Any standards developed or
2 adopted under this section shall be consistent with
3 the objectives of improving—

4 “(A) patient safety; and

5 “(B) the quality of care provided to pa-
6 tients.

7 “(3) REQUIREMENTS.—Any standards devel-
8 oped or adopted under this section shall comply with
9 the following:

10 “(A) UNDUE BURDEN.—The standards
11 shall be designed so that, to the extent prac-
12 ticable, the standards do not impose an undue
13 administrative or financial burden on the prac-
14 tice of medicine, or any other health care pro-
15 fession, particularly on small physician prac-
16 tices and practices in rural areas.

17 “(B) COMPATIBILITY WITH ADMINISTRA-
18 TIVE SIMPLIFICATION AND PRIVACY LAWS.—
19 The standards shall be—

20 “(i) consistent with the Federal regu-
21 lations (concerning the privacy and secu-
22 rity of individually identifiable information)
23 promulgated under section 264(c) of the
24 Health Insurance Portability and Account-
25 ability Act of 1996, and any State privacy

1 laws preserved under the Federal regula-
2 tions promulgated under section 1178; and
3 “(ii) compatible with the standards
4 under section 3.

5 “(b) TIMETABLE FOR ADOPTION OF STANDARDS.—

6 “(1) IN GENERAL.—The Secretary shall adopt
7 trial standards under this section two years after the
8 date of the enactment of this part, or at a subse-
9 quent date determined by the Secretary, as may be
10 required to complete development of the trial stand-
11 ards.

12 “(2) PILOT PROGRAM TO TEST TRIAL STAND-
13 ARDS.—

14 “(A) PILOT PROGRAM.—In accordance
15 with the development and adoption of stand-
16 ards, the Secretary shall conduct a pilot pro-
17 gram to test the effectiveness and impact of
18 trial standards for transaction and data ele-
19 ments as defined in subsection (a)(1)(A).

20 “(B) LOCATION OF PROGRAM.—The pilot
21 program shall be conducted through various
22 health care facilities, including small physician
23 practices, throughout the country that capture
24 both rural and urban settings.

1 “(C) DURATION OF THE PROGRAM.—The
2 pilot program shall be conducted during the
3 two-year period beginning on the date of adop-
4 tion of the standards.

5 “(D) DESIGNATION AND SELECTION OF
6 PROGRAM SITES.—In designing the pilot pro-
7 gram and in selecting locations and sites for the
8 pilot test, the Secretary shall consult with na-
9 tional organizations representing affected par-
10 ties, as defined in subsection (a)(1)(C), and ap-
11 propriate standard setting organizations, as de-
12 fined in subsection (a)(1)(B).

13 “(E) REPORT OF FINDINGS.—The Sec-
14 retary, consistent and accordance with sub-
15 sections (a)(1)(B) and (a)(1)(C), shall submit
16 to Congress a report on the pilot program no
17 earlier than one year following the completion
18 of the pilot program. The Secretary shall in-
19 clude in the report the following:

20 “(i) The Secretary’s assessment of the
21 impact and effectiveness of the trial stand-
22 ards, as applied to a variety of clinical and
23 geographic setting as described under this
24 section.

1 “(ii) The Secretary’s assessment of
2 the effect of the pilot program and trial
3 standards on patient safety, including the
4 effect on delivery and the quality of health
5 care, and on the typical costs incurred by
6 providers in acquiring necessary technology
7 systems, and the necessary training to
8 comply with the trial standards.

9 “(iii) The Secretary’s assessment of
10 the clinical usefulness of health informa-
11 tion technologies that meet the trial stand-
12 ards, including the amount of time re-
13 quired of physicians, other health profes-
14 sionals and other office staff in sending,
15 receiving, updating, maintaining, and re-
16 cording clinical information using such
17 technologies.

18 “(iv) In consultation with appropriate
19 standard setting organizations, as defined
20 in subsection (a)(1)(B), and with national
21 organizations representing affected parties,
22 as defined in subsection (a)(1)(C), the
23 findings and conclusions of the Secretary
24 with respect to the pilot program and no-
25 tice of adoption of a modified standard.

1 “(v) Any recommendations of the Sec-
2 retary for continuation of the pilot pro-
3 gram for further study or testing to other
4 clinical or geographic service areas prior to
5 full implementation.

6 “(3) ADDITIONS AND MODIFICATIONS TO
7 STANDARDS.—The Secretary shall, in consultation
8 with appropriate representatives of interested par-
9 ties, as defined in subsection (a)(1)(C) of this sec-
10 tion, and with standard setting organizations, as de-
11 fined in subsection (a)(1)(B), review the standards
12 developed or adopted under this section and adopt
13 modifications to the standards (including additions
14 to the standards), as determined appropriate. Any
15 addition or modification to such standards shall be
16 completed in a manner which minimizes the disrup-
17 tion and cost of compliance.

18 “(c) COMPLIANCE WITH STANDARDS.—

19 “(1) REQUIREMENT FOR ALL INDIVIDUALS AND
20 ENTITIES THAT UTILIZE HEALTH INFORMATION
21 TECHNOLOGY.—

22 “(A) IN GENERAL.—Individuals or entities
23 that voluntarily utilize electronic health records,
24 and other health information technology defined
25 by the Secretary as being a key component of

1 a national health care information infrastruc-
2 ture shall comply with the standards adopted or
3 modified under this section.

4 “(B) RELATION TO STATE LAWS.—Con-
5 sistent with subsection (a)(3)(B), the standards
6 adopted or modified under this section shall su-
7 persede any State law or regulations pertaining
8 to the electronic transmission of patient history,
9 eligibility, benefit and any other information.

10 “(2) TIMETABLE FOR COMPLIANCE.—

11 “(A) INITIAL COMPLIANCE.—

12 “(i) IN GENERAL.—Not later than 24
13 months after the date on which a modified
14 standard is adopted under this section,
15 each individual or entity to whom the
16 standard applies shall comply with the
17 standard.

18 “(ii) SPECIAL RULES FOR SMALL
19 HEALTH PLANS.—In the case of a ‘small
20 health plan’, as defined by the Secretary
21 for purposes of section 1175(b)(1)(B),
22 clause (i) shall be applied by substituting,
23 ‘36 months’ for ‘24 months’.

24 “(iii) SPECIAL RULE FOR SMALL PRO-
25 VIDER OF SERVICES.—In the case of a

1 small provider of services, clause (i) shall
2 be applied by substituting ‘36 months’ for
3 ‘24 months’.

4 “(iv) EXCEPTION.—In consultation
5 with national organizations representing
6 affected parties, as defined in subsection
7 (a)(1)(C), the Secretary may delay initial
8 compliance until such time as the Sec-
9 retary deems appropriate to assure max-
10 imum compliance.

11 “(d) NO REQUIREMENT TO OBTAIN SPECIFIC TECH-
12 NOLOGIES OR PRODUCTS.—Nothing in this part shall be
13 construed to require an individual or entity to obtain spe-
14 cific technologies or products to utilize a national health
15 care information infrastructure.

16 “(e) PRESERVATION OF HEALTH CARE PROVIDER OR
17 OTHER ENTITY TO MAKE UNBIASED PATIENT CARE DE-
18 CISIONS.—Interoperable health care technology shall be
19 designed to facilitate access to unbiased and evidence-
20 based decision support tools. All patient care decisions
21 shall be based solely on the provider’s clinical expertise
22 and experience, without outside influence.

23 “(f) SMALL HEALTH CARE PROVIDERS.—For pur-
24 poses of this part, a health care provider or practice is

1 considered ‘small’ if it is small under the provisions of sec-
2 tion 1862(h).

3 **“SEC. 1182. FINANCIAL INCENTIVE TO SMALL HEALTH**
4 **CARE PROVIDERS AND ENTITIES TO IMPLE-**
5 **MENT A NATIONAL HEALTH INFORMATION**
6 **INFRASTRUCTURE.**

7 “(a) IN GENERAL.—The Secretary shall include addi-
8 tional Medicare payment incentives to assure small health
9 care providers have the capability to move toward a na-
10 tional health care information infrastructure by acquiring
11 electronic health record systems and other health informa-
12 tion technologies that meet the standards adopted or
13 modified under section 1181.

14 “(b) CONDITIONS FOR QUALIFICATION.—As a condi-
15 tion of qualifying for financial incentives described in this
16 section, the Secretary, in consultation with national orga-
17 nizations representing affected parties, as defined in sec-
18 tion 1181(a)(1)(C), and appropriate standards setting or-
19 ganizations, as defined in section 1181(a)(1)(B), shall
20 grant the use of financial incentives to assure that such
21 technologies are consistent with the goals of creation of
22 a national health information infrastructure, such as—

23 “(1) voluntary participation in studies or dem-
24 onstration projects to evaluate the use of such sys-

1 tems to measure and report quality data based on
2 accepted clinical performance measures; and

3 “(2) voluntary participation in studies to dem-
4 onstrate the impact of such technologies on improv-
5 ing patient care, reducing costs and increasing effi-
6 ciencies.

7 “(c) ADDITIONAL MEDICARE PAYMENT TO SMALL
8 HEALTH CARE PROVIDERS AND ENTITIES FOR EXPENDI-
9 TURES RELATING TO THE IMPLEMENTATION OF A NA-
10 TIONAL HEALTH INFORMATION INFRASTRUCTURE.—

11 “(1) IN GENERAL.—The Secretary shall provide
12 for additional payment to small health care pro-
13 viders, including physicians and others in clinical
14 practice, for the purpose of assisting such entities to
15 implement, design, test, acquire, and adopt elec-
16 tronic health records and other health information
17 technologies defined by the Secretary as a key com-
18 ponent of a national health care information infra-
19 structure that comply with the standards adopted or
20 modified under section 1181.

21 “(2) TYPES OF REIMBURSEMENT INCEN-
22 TIVES.—In developing the reimbursement incentives
23 described in paragraph (1), the Secretary shall con-
24 sider inclusion of one or more of the following types
25 of incentives:

1 “(A) Adds-ons to payments for evaluation
2 and management services.

3 “(B) Care management fees for physicians
4 who use information technology to manage care
5 of patients with chronic illnesses.

6 “(C) Payments for structured e-mail
7 consults resulting in a separately identifiable
8 medical service from other evaluation and man-
9 agement services.

10 “(D) Any other method deemed appro-
11 priate by the Secretary to encourage participa-
12 tion.

13 “(3) AMOUNT OF REIMBURSEMENT.—The
14 amount of reimbursement made to small health care
15 providers and entities to implement a national health
16 care information infrastructure shall be in a manner
17 determined by the Secretary, in accordance with sec-
18 tion 1181(b)(2)(ii), that takes into account the costs
19 of implementation, training, and complying with
20 standards.

21 “(4) EXEMPTION FROM BUDGET NEUTRALITY
22 UNDER THE PHYSICIAN FEE SCHEDULE.—Any in-
23 creased expenditures pursuant to this section shall
24 be treated as additional allowed expenditures for

1 purposes of computing any update under section
2 1848(d).

3 **“SEC. 1183. OPTIONAL FINANCIAL INCENTIVES TO SMALL**
4 **HEALTH CARE PROVIDERS AND ENTITIES TO**
5 **IMPLEMENT A NATIONAL HEALTH INFORMA-**
6 **TION INFRASTRUCTURE.**

7 “(a) IN GENERAL.—The Secretary may utilize any,
8 all, or a combination of financial incentives thereof, to as-
9 sure small health care providers have the capability to
10 move toward a national health care information infra-
11 structure by acquiring electronic health record systems
12 and other health information technologies that meet the
13 standards adopted or modified under section 1181.

14 “(b) CONDITIONS FOR QUALIFICATION.—As a condi-
15 tion of qualifying for financial incentives described in this
16 section, the Secretary, in consultation with national orga-
17 nizations representing affected parties, as defined in sec-
18 tion 1181(a)(1)(C), and appropriate standards setting or-
19 ganizations, as defined in section 1181(a)(1)(B), shall
20 grant the use of financial incentives to assure that such
21 technologies are consistent with the goals of creation of
22 a national health information infrastructure, such as—

23 “(1) voluntary participation in studies or dem-
24 onstration projects to evaluate the use of such sys-

1 tems to measure and report quality data based on
2 accepted clinical performance measures; and

3 “(2) voluntary participation in studies to dem-
4 onstrate the impact of such technologies on improv-
5 ing patient care, reducing costs and increasing effi-
6 ciencies.

7 “(c) GRANTS TO SMALL HEALTH CARE PROVIDERS
8 AND ENTITIES FOR EXPENDITURES RELATING TO THE
9 IMPLEMENTATION OF A NATIONAL HEALTH INFORMA-
10 TION INFRASTRUCTURE.—

11 “(1) IN GENERAL.—The Secretary is authorized
12 to make grants to small health care providers, in-
13 cluding physicians and others in clinical practice, for
14 the purpose of assisting such entities to implement,
15 design, test, acquire, and adopt electronic health
16 records and other health information technologies
17 identified by the Secretary as a key component of a
18 national health care information infrastructure that
19 comply with the standards adopted or modified
20 under section 1181.

21 “(2) AMOUNT OF GRANT.—The grant amount
22 made to small health care providers and entities to
23 implement a national health care information infra-
24 structure shall be in a manner determined by the
25 Secretary, in accordance with section 1181(b)(2)(ii),

1 that takes into account the costs of implementation,
2 training, and complying with standards.

3 “(3) APPLICATION.—No grant may be made
4 under this subsection except pursuant to a grant ap-
5 plication that is submitted in a time, manner, and
6 form approved by the Secretary.

7 “(4) AUTHORIZATION OF APPROPRIATIONS.—
8 There are authorized to be appropriated to carry out
9 this subsection such sums as may be necessary for
10 each fiscal year.

11 “(d) REVOLVING LOANS TO SMALL HEALTH CARE
12 PROVIDERS AND ENTITIES FOR EXPENDITURES RELAT-
13 ING TO THE IMPLEMENTATION OF A NATIONAL HEALTH
14 INFORMATION INFRASTRUCTURE.—

15 “(1) IN GENERAL.—The Secretary is authorized
16 to make and guarantee loans to small health care
17 providers, including physicians and others in clinical
18 practice, for the purpose of assisting such entities to
19 implement, design, test, acquire, and adopt elec-
20 tronic health records and other health information
21 technologies identified by the Secretary as a key
22 component of a national health care information in-
23 frastructure that comply with the standards adopted
24 or modified under section 1181.

1 “(2) AMOUNT OF LOAN.—The loan amount
 2 made to small health care providers and entities to
 3 implement a national health care information infra-
 4 structure shall be in a manner determined by the
 5 Secretary, in accordance with section 1181(b)(2)(ii),
 6 that takes into account the costs of implementation,
 7 training, and complying with standards.

8 “(3) APPLICATION.—No loan may be made
 9 under this subsection except pursuant to a loan ap-
 10 plication that is submitted in a time, manner, and
 11 form approved by the Secretary.

12 “(4) AUTHORIZATION OF APPROPRIATIONS.—
 13 There are authorized to be appropriated to carry out
 14 this subsection such sums as may be necessary for
 15 each fiscal year.”.

16 **SEC. 5. REFUNDABLE CREDIT FOR HEALTH CARE INFOR-**
 17 **MATION INFRASTRUCTURE.**

18 (a) IN GENERAL.—Subpart C of part IV of sub-
 19 chapter A of chapter 1 of the Internal Revenue Code of
 20 1986 (relating to refundable credits) is amended by redes-
 21 ignating section 36 as section 37 and by inserting after
 22 section 35 the following new section:

23 **“SEC. 36. HEALTH CARE INFORMATION INFRASTRUCTURE.**

24 “(a) IN GENERAL.—In the case of a qualified health
 25 care provider, there shall be allowed as a credit against

1 the tax imposed by this chapter for the taxable year an
2 amount equal to 10 percent of the amounts paid or in-
3 curred during the taxable year by the taxpayer for estab-
4 lishing a qualified health information technology system.

5 “(b) QUALIFIED HEALTH INFORMATION TECH-
6 NOLOGY SYSTEM.—For purposes of this section, the term
7 ‘qualified health information technology system’ means a
8 system which has been individually approved by the Sec-
9 retary of Health and Human Services for purposes of this
10 section and which consists of electronic health record sys-
11 tems and other health information technologies that meet
12 the standards and conditions of qualification adopted or
13 modified under sections 1181 and 1183 of the Social Secu-
14 rity Act.

15 “(c) QUALIFIED HEALTH CARE PROVIDER.—For
16 purposes of this section, the term ‘qualified health care
17 provider’ means any person in the trade or business of
18 providing health care.

19 “(d) TERMINATION.—This section shall not apply to
20 amounts paid or incurred during taxable years beginning
21 after December 31, 2014.”.

22 (b) DENIAL OF DOUBLE BENEFIT.—Section 280C of
23 such Code is amended by adding at the end the following
24 new subsection:

1 “(e) CREDIT FOR HEALTH CARE INFORMATION IN-
 2 FRASTRUCTURE.—No deduction shall be allowed for that
 3 portion of the expenses (otherwise allowable as a deduc-
 4 tion) taken into account in determining the credit under
 5 section 36 for the taxable year which is equal to the
 6 amount of the credit determined for such taxable year
 7 under section 36(a).”.

8 (c) CONFORMING AMENDMENTS.—

9 (1) Paragraph (2) of section 1324(b) of title
 10 31, United States Code, is amended by inserting “or
 11 36” after “section 35”.

12 (2) The table of sections for subpart C of part
 13 IV of subchapter A of chapter 1 of the Internal Rev-
 14 enue Code of 1986 is amended by striking the item
 15 relating to section 36 and inserting the following
 16 new items:

“Sec. 36. Health care information infrastructure.
 “Sec. 37. Overpayment of taxes.”.

17 (d) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to amounts paid or incurred during
 19 taxable years beginning after December 31, 2005.

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